American Society of Anesthesiologists®

Timely Topics
PAYMENT AND PRACTICE MANAGEMENT

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What Anesthesiologists Need to Know about Reporting E&M or TCM

Anesthesia services are typically paid based on the "base value + time" methodology described in the ASA Relative Value Guide®. Payment for anesthesia care includes all activities related to the preoperative assessment, intraoperative management and routine postoperative care. In some cases additional payment is made for selected procedures, such as placement of central lines, pulmonary artery catheters, cardiac ultrasound, etc. As noted in the ASA Relative Value Guide, *"The usual anesthesia services included in the Base Unit Value include the usual pre-operative and post-operative visits, the administration of fluids and/or blood products incident to the anesthesia care and interpretation of non-invasive monitoring (ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry). Placement of arterial, central venous and pulmonary artery catheters and use of transesophageal echocardiography (TEE) are not included in the base unit value."*

As anesthesiologists assume a broader role in perioperative care, there may be other opportunities to bill for clinical services beyond those included in the anesthesia codes. Coding and documentation requirements related to these services are different than the traditional anesthesia billing requirements which include routine pre-, intra- and postoperative management. This article describes the clinical services that might be billed using evaluation and management (E&M) codes and the requirements for billing for transitional care management related to services provided to patients when the services are provided to patients during the 30-day period following discharge from a hospital admission, observational status or nursing home.

Evaluation and Management Services

Under specific conditions, E&M services can be billed using the appropriate E&M code that reflects the level of service provided to the patient; however, to bill for E&M services requires that ***specific criteria are met*** and that the services can be clearly differentiated from those included as part of the anesthesia services. In order for an anesthesiologist to bill for E&M services related to a proposed surgical procedure separately from the billing for an anesthesia service, there must be documentation of the medical necessity for the evaluation and a description of the clinical services provided. In some cases, a surgeon might request that the anesthesiologist determine ***if*** a patient's clinical condition is optimized to allow scheduling of a surgical procedure and, if not, request assistance in ***managing*** the preoperative care (e.g., assessing and managing underlying clinical conditions, such as coronary artery disease, chronic obstructive pulmonary disease, asthma, diabetes mellitus, etc.). These management services are beyond the scope of routine preoperative evaluation and are separately billable with appropriate documentation.

The documentation of these preoperative E&M services must include relevant elements of the patient's history, physical examination and the level of decision-making required for the E&M code reported by anesthesiologist. In most cases, these preoperative E&M services will be provided on an outpatient basis and will be reported by CPT codes 99201-99205 for a new patient or 99211-99215 for an established patient, as defined in the CPT Manual. In some cases, anesthesiologists may be requested to provide preoperative E&M services to an inpatient to manage their medical conditions prior to surgical interventions. In such cases, that care will likely be reported with CPT codes 99231-99233.

Physicians should be aware that the level of E&M service reported is determined by the level of history, physical exam and decision-making required by the patient's conditions. It is not enough to simply provide a higher degree of service, but the patient's medical condition must **require** that level of service and all required elements must be documented according to guidelines established by CPT and by the Centers for Medicare and Medicaid Services (CMS). For more information on CMS guidelines for E&M, please see http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf

There are other situations in which an anesthesiologist might perform E&M services and bill separately for the services unrelated to the anesthetic management. For example, the surgeon may request assistance from the anesthesiologist in the management of postoperative pain that is not amenable to usual pain management strategies. When providing this, or any other service unrelated to the routine anesthesia care, the key issues from a coding and billing perspective are that there be (1) specific and detailed documentation of the request, (2) clarification that the service is not included in routine perioperative anesthesia care which is covered by the anesthesia charge and (3) appropriate documentation of the extent of the clinical evaluation and clinical decision-making to support the claim and billing code.

Transitional Care Management Services

Some anesthesiologists have expressed an interest in providing Transitional Care Management (TCM) services to patients. TCM codes are used to document clinical services provided to patients for the ***30-day period after hospital discharge***, observational status or discharge from other inpatient facilities. Only those practice models that include services provided by the anesthesiologist to patients within this post-discharge period are eligible to submit claims for TCM. While the use of these codes will be rare for most anesthesia practices, each practice should understand the requirements under which the TCM codes are appropriate and what is required to use these codes.

The criteria that must be met to report the TCM codes include three critical elements that must be provided beginning on the day of discharge and extending for the next 29 days.

The elements include (1) communication with the patient or designated caregiver within two business days of discharge, (2) medical decision-making of a least a moderate level of complexity, and (3) a ***face to face visit*** within 7 or 14 days of discharge depending on the level of complexity. The communication requires discussion with the patient or patient representative about the patient's clinical needs, required services, education and ongoing assessment and support to ensure adherence to the treatment plan, as well as assistance in identifying the need for and facilitating access to other clinical care and services that may be needed in the post-discharge period. In addition, when billing for TCM, the provider assumes responsibility for managing and/or coordinating all services including, but not limited to medical conditions, psychosocial needs, activities of daily living and continuous access to the provider.

Documentation of TCM services is provided through the use of one of two codes – 99495 (moderate complexity) or 99496 (high complexity). The specific services provided for each code are the same, except for the level of complexity of medical decision-making, generally related to the complexity of care needs identified at the time of discharge, and the time between discharge and the required face-to-face visit (14 days for 99495 vs. 7 days for 99496).

Billing for E&M services or TCM is complex and requires a different level of interaction with patients and other providers than do most anesthesia services. Some practices have expanded their roles to provide this level of clinical care; in doing so, they should be familiar with and ensure that those anesthesiologists who provide these clinical services understand their obligation to the patient and the documentation requirements to support the use of E&M or TCM codes.